ZoeAcupuncture

Holistic Wellness for Elevated Living

Zoe Meininger L.Ac., Dipl. OM
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CONFIDENTIAL PATIENT INFORMATION

(please download PDF, fill out, and email to ZoeAcupunctureTCM@gmail.com before your first visit)

Name_____
First Last

Address_____
Street City State Zip

Phone number_____ Email address_____

Age_____ Date of Birth _____ Sex: M ☐ F ☐
MM DD YY

Emergency contact:_____
Name Relation Phone #

*How did you hear about ZoeAcupuncture? _____

*Have you ever had acupuncture before? _____

*Occupation or profession _____

*This information is helpful, but optional. All other information is mandatory.

ZOEACUPUNCTURE, LLC TERMS AND CONDITIONS OF SERVICE

INFORMED CONSENT TO ACUPUNCTURE TREATMENT AND CARE

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or the patient named below for whom I am legally responsible) by licensed acupuncturist, Zoe Meininger.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Oriental Massage), Oriental herbal medicine, Gua Sha, nutritional counseling, and lifestyle recommendations. I understand that the preparation, ordering and shipment of herbal supplements and formulas will take time and may require waiting up to a few days. Prescribed teas, herbs, and formulas need to be consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or bitter taste. I will immediately notify Zoe Meininger of any unanticipated or unpleasant effects associated with the consumption of the herbs and/or supplements.

I have been informed that acupuncture is a generally safe method of treatment, but that I may have some side effects, including bruising (especially on the face), numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although this clinic uses sterile, disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Oriental Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify Zoe Meininger, or a clinic staff member, who is caring for me if I am or become pregnant.

I do not expect Zoe Meininger, or the clinical staff to be able to anticipate and explain all possible risks and complications of treatment. I wish to rely on Zoe Meininger to exercise judgment during the course of my treatment, and will rely on what she thinks is best at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed. I understand that Zoe Meininger, and the administrative staff of ZoeAcupuncture, may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment; have been told about the risks and benefits of acupuncture and other procedures and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

FINANCIAL AGREEMENT

Payment is due at the time of service, unless other prior arrangements have been made. ZoeAcupuncture may provide you with receipts, or a super-bill, for insurance reimbursement.

ZOEACUPUNCTURE 24-HOUR CANCELLATION POLICY

There is a 24-Hour Cancellation Policy in effect. If an appointment must be cancelled within the 24-hour period, the cost of the appointment will be billed to the patient.

PATIENT NAME:_____ DATE:_____

SIGNATURE:_____

COLORADO MANDATORY DISCLOSURE STATEMENT for ZOEACUPUNCTURE, LLC

Education and Experience:

Zoe Meininger earned her Masters of Traditional Oriental Medicine degree from Emperor's College of Traditional Oriental Medicine in October 2011. This four-year program consists of 3210 instructional hours, or 224 didactic units, and 970 hours of clinic training, including a clinical externship at the UCLA Arthur Ashe Center under the supervision of Dr. Robert Chu, PhD, L.Ac., QME. Zoe was certified as a Diplomate of Oriental Medicine by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in December 2019. This includes certification in Clean Needle Technique, Acupuncture, Biomedicine, Chinese Medical Theory, and Chinese Herbology.

Zoe's training includes adjunctive therapies such as moxibustion, cupping, Tui Na, acupressure, auriculotherapy, Gua Sha, and dietary and lifestyle recommendations.

Zoe is a licensed acupuncturist in the states of California and Colorado. Her California license is currently on "Inactive" status. None of her licenses or certificates has ever been suspended or revoked.

This clinic complies with the rules and regulations promulgated by the Colorado Department of Health, including the proper cleaning and sterilization of needles and of all adjunctive acupuncture tools, and the sanitation of acupuncture offices. Only single-use, disposable, factory-sterilized acupuncture needles are utilized.

Fee Schedule

Initial Intake, Consultation, and Treatment	$225 + cost of herbs
Follow-up Consultation and Treatment	$175 + cost of herbs
Cosmetic Acupuncture Treatment	$250 + cost of herbs
Home Visit Treatment	$350 + cost of herbs

Patient's Rights

- The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known.
- The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time.
- In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registrations in the Department of Regulatory Agencies.

The practice of acupuncture is regulated by the Director of Registrations, Colorado Department of Regulatory Agencies. If you have comments, questions, or complaints, contact the Acupuncturists Registration Office, 1560 Broadway, Suite 1350, Denver, Colorado, 80202. Telephone: (303) 894- 2440.
I have read and understand this document.

PATIENT NAME:_____DATE:_____

SIGNATURE:_____

HIPPA Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

• Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
• Obtain payment from third-party payers.
• Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

MEDICAL CONSENT

I have read and fully understand the policies of ZoeAcupuncture. I, the patient, or the patient's representative, accept the full responsibility to follow up the medical advice given at ZoeAcupuncture. I, the patient, or the patient's representative, consent to the treatment procedures and it's results, and repercussions thereof, and accept arbitration if deemed necessary.

RELEASE OF INFORMATION

ZoeAcupuncture will, only through a patient completing a specific and separate Authorization for Release of Information form, or in compliance with a legal subpoena, furnish from the patient's record necessary information to the referring physician, if any, and to others to the extent required in connection with a claim for aid, insurance, or medical assistance to which the patient may be entitled.

PATIENT NAME:_____DATE:_____

SIGNATURE:_____

MEDICAL HISTORY QUESTIONNAIRE

Please complete the following as accurately as possible. All information is confidential

Patient Name:_____ Date _____

PRESENT CONDITION:

What is your chief complaint?

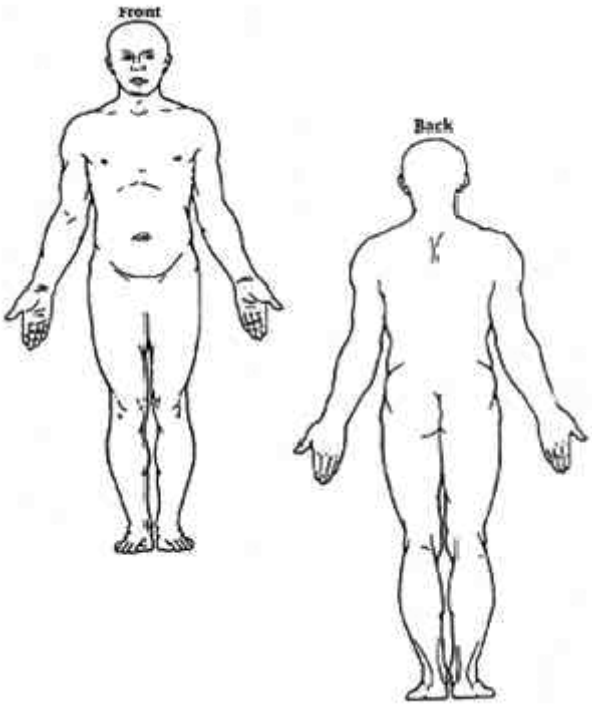
_____

When did this condition begin?

_____

What treatment have you already received?

_____



MEDICAL HISTORY:

What vitamins/ supplements are you taking?

_____

What surgeries have you had? When did you have them?

_____

What other serious injuries or illnesses have you had?

_____

Do you have any allergies that you know of?

_____

INFECTION HISTORY:
_____ HIV/AIDS, or HIV risks: Self or partner
_____ Tuberculosis (TB): Self or household
_____ Hepatitis, or Hepatitis risk: Self of partner
_____ MRSA, Staph, CRE, or other drug-resistant infections

PRIMARY CARE PHYSICIAN'S NAME AND CONTACT INFORMATION:

Name:_____ Phone:_____

TO BE COMPLETED BY PATIENT:

NAME:_____DATE:_____

SIGNATURE:_____

Notice of Privacy Practices

Dear Valued Patient,

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected. In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company¸ with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.

Safeguards in place at our office include:

Limited access to facilities where information is stored.

Policies and procedures for handling information.

Requirements for third parties to contractually comply with privacy laws.

All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Types of information that we gather and use:

In administering your health care, we gather and maintain information that may include non-public personal information about your financial transactions with us (billing transactions), from your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners, and from health care providers, insurance companies, workman's comp and your employer, and other third part administrators (*e.g*. requests for medical records, claim payment information).

In certain states, you may be able to access and correct personal information we have collected about you, (information that can identify you - *e.g.* your name, address, Social Security number, etc.).

We value our relationship, and respect your right to privacy. If you have questions about our privacy guidelines, please call us during regular business hours at 970-379-9005.

Acknowledgement of Receipt of Notice of Privacy Practices

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation according to current HIPPA laws and regulations.

I, _____, hereby acknowledge that Zoe Meininger, L.Ac.

provided me with a copy of the Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information.

I understand that if I have questions or complaints I may contact: Zoe Meininger, L.Ac. • 970-379-9005

I also understand that I am entitled to receive updates upon request if Zoe Meininger, L.Ac. amends or changes the Notice of Privacy Practices in a material way.

NAME:_____. DATE:_____

SIGNATURE:_____